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20th April 2021

Dear Mr Osborn,

Thank you for your letter of 6th April, your email of the 18th April and for providing me with a copy of your report. I recognise the time, effort and dedication you have invested into this work and I have sought to extract what I respectfully believe to be the main issues you convey in your letter and email and will look to address each in turn.

1. **HSE Research Report 619**

You cite HSE Research Report [RR619 Evaluating the protection afforded by surgical masks](#) (RR619) and suggest it contradicts official guidance, specifically in relation to the efficacy of surgical masks in comparison to tight fitting respirators.

It is important to clarify that RR619 addressed a specific research question, namely, what level of protection is afforded to the wearer by surgical masks when exposed to an influenza virus aerosol?

The methodology used in RR619 consisted of fitting a range of surgical masks to a breathing manikin and challenged them to an aerosol of flu virus generated from a nebuliser at a distance of 70 cm, comparing the amount of virus in front of the mask with the amount inside the mask therefore going through the fabric or round through leaks. Within the executive summary, the report comments:

“In principle, surgical masks that are worn correctly should provide adequate protection against large droplets, splashes and contact transmission. They may also reduce to some degree any residual aerosol risk, although this level of protection might not sufficiently reduce the likelihood of transmission via this route. Consequently

they should not be used in situations where close exposure to infectious aerosols is likely."

Current Four Nations COVID-19 Infection Prevention and Control (IPC) guidance for healthcare settings, as you note, recommends the use of FFP3 masks when providing direct patient care and performing aerosol generating procedures (AGPs) to possible or confirmed cases of COVID-19. The guidance does not recommend the use of surgical masks when performing AGPs with possible or confirmed cases. Therefore, RR619 does not contradict this guidance.

It should be noted that RR619 did not assess effectiveness of surgical masks at a distance greater than 70cm, and therefore cannot be used as evidence of wider transmission risk beyond this distance. In addition, it is also not within the scope of RR619 to define what is or is not an infectious aerosol, and therefore cannot be used to challenge the official list of AGPs provided.

2. Risks to healthcare workers (HCW) and transmission evidence

As you are aware, the latest Four Nations IPC guidance for infection prevention and control in healthcare was published on 21 January 2021 following a clinical and scientific review of the new variants. No changes to the recommendations, including personal protective equipment (PPE), were made, however this position remains under constant review. Indeed, HSE recently contributed to a paper that will shortly be published by SAGE (Scientific Advisory Group on Emergencies). The paper reviewed the evidence on SARS-CoV-2 transmission and mitigation in UK health and care settings, with a specific focus on small particle aerosols and healthcare worker (HCW) facemasks. The paper is scheduled for publication on 23 April 2021 and includes data from a range of sources including HSE.

You also mention ONS (Office for National Statistics) data that shows a higher level of mortality from COVID-19 among certain occupational groups. There is uncertainty about the extent to which this reflects true differences in the risk of infection in the workplace: the Industrial Injuries Advisory Council have so far concluded that the evidence is not sufficient to attribute particular COVID-19 deaths as occupational on the balance of probabilities. We are aware that further analyses are taking place to investigate the role occupation may play among other factors such as ethnicity and deprivation status in these statistics, and publications in this area are expected soon.

HSE visited 17 hospitals during November 2020 and January 2021 to measure their compliance against official government guidance on COVID-19 control measures. Whilst all of the hospitals inspected had been working hard to ensure adequate controls were in place, we wrote to eight requiring improvements to be made and the common areas were in relation to social distancing, cleanliness and ventilation in non-clinical areas. These inspections highlighted that many hospitals could do significantly more to reduce the risk of virus transmission to as low as reasonably practicable before additional PPE is considered.

We shared the findings with all NHS trusts and health boards and with the tripartite Health, Safety and Wellbeing Partnership Group, which is a national sub-group of the NHS Staff Council, attended by NHS employers and our trade union colleagues, from the Royal College of Nursing, Unison and Unite, to ensure wider learning across the sector.

3. HSE enforcement

I can reassure you that there has been no external pressure on HSE to enforce in a particular way in relation to the COVID pandemic. HSE continues to investigate COVID-19 cases of disease and deaths where they meet our published incident selection criteria. Inspectors will take proportionate enforcement action where it is needed and will ensure that all necessary risk controls are in place before the intervention is completed.

HSE will continue to advise and enforce in line with the current Four Nations IPC guidance as currently there is insufficient evidence to suggest that additional controls are required. The emerging picture is complex, but we consider there are many factors affecting the nosocomial rate of infection amongst HCW's. It is therefore important that all controls are stringently applied, including, social distancing, hand hygiene, cleaning regimes, ventilation in addition to the IPC requirements for PPE etc. In addition, robust arrangements are needed to supervise, monitor and review the control measures to ensure they remain effective.

As you know several colleagues are involved across HSE in the areas discussed above and they also reviewed your letter and report and contributed to my response. In doing so I hope I have addressed the issues you raise. I also appreciate your invitation, but as HSE does not lead on the IPC guidance we do not need to be represented at the AGP Alliance meeting with DHSC and others on 22 April 2021, however I can assure you that the health and safety of HCW's continues to be a priority for us and we will continue to ensure that guidance and emerging evidence is kept under review.

Yours sincerely,



Sarah Albon

Chief Executive